PM FORM 3.15.1
Informed Consent for Psychotropic Medication Treatment

(Link to Spanish Version)

Person's Name: _____

I, _____, have been given information by my
(Person/Guardian/Other Responsible Party Printed Name)

medical practitioner, (*Physician, Nurse Practitioner, or Physicians Assistant*), about each medication listed below.

For each medication listed, I have been given the opportunity to discuss with my medical practitioner the following:

- The diagnosis and target symptoms for the medication recommended
- The possible benefits**/**intended outcome of treatment, and as applicable, all available procedures involved in the proposed treatment
- The possible risks and side effects
- The possible alternatives
- The possible results of not taking the recommended medication
- The possibility that my medication dose may need to be adjusted over time, in consultation with my medical practitioner
- My right to actively participate in my treatment by discussing medication concerns or questions with my medical practitioner
- My right to withdraw voluntary consent for medication at any time (unless the use of medications in my treatment are required in a Court Order or in a Special Treatment Plan)

- I understand the medication information that has been provided to me. By signing below I agree to the use of each medication. -

Medication	Person/Guardian/Other Responsible Party Signature	Medical Practitioner's Printed Name	Medical Practitioner's Signature	Date

Last Revised: 08/01/2004